

Marywood University, Student Health Services
Loughran Hall
2300 Adams Ave.
Scranton, PA 18509
Phone: 570-348-6249 Fax: 570-961-4735

*Medical records will only be mailed or faxed directly to you.
Please make copies for your records, as there will be a \$5 fee for future requests.*

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Marywood University Student Health Services to release by: Mail **OR** Fax to:

*** Please Print**

Patient Name: _____ SS# XXX – XX – _____
Last four digits

Current Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Date of Birth: _____

Fax: _____

Check appropriate line:

- My latest Health History and Physical
- Diagnostic test only
Type(s) _____
Date(s) _____
- Immunizations/PPD Results & associated chest X-ray/Titers
- Other: _____

Reason for disclosure: _____

- I understand that this request for release of information stands effective for 120 days or until _____. I may revoke this Authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to: Marywood University Student Health Services, Loughran Hall, 2300 Adams Ave. Scranton, PA 18509. My revocation will be effective upon receipt, but will not be effective to the extent that Marywood University Student Health Services has taken action in reliance upon this Authorization.
- Disclosure of specific information authorized for release is limited to the above-mentioned recipient only.
- I understand that treatment, payment, enrollment or eligibility for benefits at Marywood University Student Health Services cannot be conditioned on the signing of this authorization.
- I also understand that once released, Marywood University Student Health Services has no control over any disclosure of my records that may occur, and my information may be subject to redisclosure by the recipient and no longer protected.

Signature: _____ Date: _____ Time: _____

Print Name: _____

If not signed by the patient, indicate your relationship/authority to sign for the patient: _____

----- To be completed by Student Health Services Only -----

Records were Mailed: _____ **By** _____
Date Signature